REQUIREMENTS/INFORMATION - ADVANCED PRACTICE REGISTERED NURSES PRESCRIPTIVE AUTHORITY (APRN-RX)

Access this form via website at: **www.state.hi.us/dcca/pvl**

NO RECIPROCITY

Hawaii does not reciprocate with any other state or jurisdiction. Each applicant is required to meet requirements according to Hawaii laws and rules.

DEFINITIONS

"Advanced practice registered nurse (APRN)" means a Hawaii licensed registered nurse who has met the requirements of and received recognition as an advanced practice registered nurse from the Board of Nursing as a nurse practitioner, clinical nurse specialist, certified nurse midwife or nurse anesthesist.
"Board" means the Hawaii Board of Nursing.
"Collegial" means the power or authority vested equally in each of the working parties.
"Contact hour" means a minimum of fifty minutes of actual organized instruction. Academic credit will be converted to contact hours as follows:

(1) One quarter academic credit equals ten contact hours; and
(2) One semester academic credit equals fifteen contact hours.

"Department" or "DCCA" means the department of commerce and consumer affairs.
"Institution" means hospitals, health maintenance organizations, home health agencies, hospice programs, community health centers receiving State or federal funds, state agencies, clinics, physicians' offices, long term care facilities, and authorized contractors of the State.
"Physician" means a person licensed under chapter 453 or 460, Hawaii Revised Statutes.
"Recognized national certifying body" means credentialing agencies recognized by the board which include the American Nurses Credentialing Center; the National Certification Board of Pediatric Nurse Practitioners/Nurses; the National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties; the American College of Nurse Midwives Certification Council; the American Academy of Nurse Practitioners; or a national certifying body which is a successor to any body listed and recognized by the board.

PREREQUISITES

Each applicant is required to have a current and unencumbered recognition as an Advanced Practice Registered Nurse ("APRN") and be currently licensed as a Registered Nurse ("RN") in Hawaii. Three separate applications are required: RN, APRN and APRN-RX.

DOCUMENTS REQUIRED

1. Application form: You must attach the $50 application fee (non-refundable) for your application to be reviewed. You may attach the other fees or you may send those in later upon approval of your application; however, the effective date of your prescriptive authorization will be delayed until all fees have been paid.

   We are creating a separate file for APRN-RX recognition. As such, this file requires original documentation as required below. Similar documents that may be in Hawaii APRN recognition file will not be transferred unless recognition granted no more than 12 months prior.

2. Master's degree transcript: Arrange with your school to have your official transcript of a master's degree in clinical nursing or nursing science sent directly to the Department of Commerce & Consumer Affairs ("DCCA").

3. Certification of nursing practice specialty: Arrange with the recognized national certifying body to have proof of your current certification sent directly to DCCA.

4. Proof of education in advanced pharmacology, including advanced pharmacotherapeutics: Arrange with your educational institution or continuing education course provider to provide verification of the item you checked in question 3 of your application form.

   To facilitate the review of your application, and to receive proper credit for your coursework, attach course descriptions from your college/university catalog or continuing education course provider. The applicant has the burden of proving he/she meets recognition requirements.

5. Proof of 1,000 hours of clinical experience: You must use the form included in this packet. Hawaii requires a minimum of 1,000 hours of clinical experience in an institution (hospital, health maintenance organization, home health agency, hospice program, community health center receiving State or federal funds, state agency, clinic, physician's office, long term care facility, and authorized contractor of the State) as a Hawaii Nursing Board-recognized APRN practitioner in the applicant's nursing practice specialty, within a three-year time period immediately preceding the date of application. This form must be completed by someone other than yourself.

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DOCUMENTS REQUIRED (cont.)

6. Collegial Working Relationship Agreement: You must use the form included in this packet. Submit the completed original form. Be advised that any illegible or unclear information will necessitate return of the form to the applicant for clarification **YOU MUST ALSO INCLUDE YOUR INTERIM PHYSICIAN ("I") ON THIS FORM**.

FEES

Submit appropriate payment as follows (make check payable to "COMMERCE AND CONSUMER AFFAIRS"):

If you expect prescriptive authority to be granted in an EVEN-NUMBERED year, pay $160
($50 - application fee + $20 - RX fee + $70 - Compliance Resolution Fund + $20 - ½ renewal)

If you expect prescriptive authority to be granted in an ODD-NUMBERED year, pay $105
($50 - application fee + $20 - RX fee + $35 - Compliance Resolution Fund)

The $50 application fee is non-refundable.

Modification of the Collegial Working Relationship Agreement Between a Recognized APRN and Physician fee (modification made after approval of the initial Agreement) pay $50

NOTE: *One of the numerous legal requirements that you must meet in order for your new recognition to be issued is the payment of fees as set forth in this application. You may be sent a recognition certificate before the check you sent us for your required fees clears your bank. If your check is returned to us unpaid, you will have failed to pay the required RX fee and your recognition will not be valid, and you* ***may not*** *do business under that recognition. Also, a $15.00 service fee will be charged for checks which are returned by the bank.*

If for any reason you are denied the recognition you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for recognition has been denied.

MAILING ADDRESS

APRN-RX Recognition Program
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801
or
Deliver to office location at:
1010 Richards St., 1st Floor
Honolulu, HI 96813

Phone: (808) 586-3000

Toll free voice access numbers for the neighbor islands:
Kauai - 274-3141 Ext. 6-3000
Maui - 984-2400 Ext. 6-3000
Hawaii - 974-4000 Ext. 6-3000
Molokai - 1-800-468-4644 Ext. 6-3000
Lanai - 1-800-468-4644 Ext. 6-3000

APPLICATION STATUS

APRN prescriptive authority requirements are subject to change as a result of new laws or rules, or from new policies and procedures adopted by the Department of Commerce & Consumer Affairs ("DCCA"). Applicants must meet current recognition requirements.

It is the responsibility of the applicant to arrange for submission of all required documentation for timely completion of the application. The DCCA does NOT have an obligation to notify applicants of incomplete documentation. Applicants may contact DCCA periodically to monitor the status of their file with regard to the receipt of supporting documents.

You may write, or call the Licensing Branch at (808) 586-3000; We do not accept, nor send, application materials by fax.

Applications are kept for two years after filing, after which DCCA will discard applications. Therefore, applicants must complete all requirements within two years of filing the application.

LAWS AND RULES

APRN-RX is held accountable for knowing and complying with the laws and rules of advanced practice registered nurse prescriptive authority practice as failure to comply may result in disciplinary action. Obtain copies by sending check or money order made payable to "COMMERCE AND CONSUMER AFFAIRS", Cashiers Office, DCCA, P.O. Box 541, Honolulu, HI 96809.

- Advanced Practice Registered Nurse Prescriptive Authority, Hawaii Administrative Rules, Chapter 89C ..... $ .75
- Nurses, Hawaii Revised Statutes, Chapter 457 ..... $ .50
- Nurses, Hawaii Administrative Rules, Title 16, Chapter 89 ..... $ 1.25
- Professional & Vocational Licensing Law, Hawaii Revised Statutes, Chapter 436B ..... $ .50
- Food, Drugs & Cosmetics, Hawaii Revised Statues, Chapter 328 ..... $ 1.25

Prices are subject to change without notice.

The laws are posted on the internet at: www.capitol.hawaii.gov/. Select from the menu "Status and Documents", then search "Hawaii Revised Statutes". Enter the specific chapter and section. The rules are posted on our website at: www.state.hi.us/dcca/pvl, then search the specific board/program.

ADDRESS CHANGES

Report your change of address in writing. Report each change of address separately, and the effective date of change.

RENEWAL OF RECOGNITION

All APRN-RX authority, regardless of when issued, expire on December 31 of each **odd-numbered** year and are subject to renewal by the expiration date. A "Renewal Application" is mailed approximately 60 days prior to the expiration date to your last address on file with DCCA. DCCA is not responsible for non-receipt of any mail. The burden is on the APRN-RX to ensure that his/her recognition is kept current.

Refer to section 16-89C-20, Advanced Practice Registered Nurse Prescriptive Authority, Hawaii Administrative Rules, for license renewal requirements on current certification, continuing education, etc.

ORAL CODE DESIGNATION

The Department of Health, Food & Drug Branch, in cooperation with the Department of Public Safety, Narcotics Enforcement Division ("NED"), has jurisdiction over assignment of your oral code designation.

When DCCA approves your application for prescriptive authority, you will be mailed an "Application for Oral Code" form and instructions, together with your "Notice of Prescriptive Authority". You may submit the "Application for Oral Code" to the Narcotics Enforcement Division at that time, if you wish to have an oral code.

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

APPLICATION - ADVANCED PRACTICE REGISTERED NURSE PRESCRIPTIVE AUTHORITY (APRN-RX)

Read the attached instructions before completing this form. Print legibly or type

Approval date	Ineligible	Initial
Date Effective:	Recognition No. RX-	
RN - Exp 6/_____		
APRN - Exp 6/_____		

OFFICE USE ONLY

Legal Name (First-Middle)	(LAST)
Other Names Used (include maiden name)	
Residence Address (include Apt. No., City, State and Zip Code) – REQUIRED	
Mailing address (if different from above)	

Social Security No.	Hawaii APRN Recognition No.	Effective date of Hawaii Recognition
Phone No. (days)	Board of Nursing Approved Specialty/Code:	
Hawaii RN License No.		

Circle answers and give details when required:

1. Have you arranged for an official transcript of a master's degree in clinical nursing or nursing science, be sent directly from the school to DCCA? ..... YES NO

   Name of school: _____ Graduation date: _____

2. Have you arranged for verification of current certification in your practice specialty, be sent from a national certifying body recognized by the Hawaii Board of Nursing to DCCA? ..... YES NO

   Name of certifying body: _____

3. Which one of the following have you successfully completed within the three-year period immediately preceding this application AND have you enclosed verification of such successful completion from your educational institution or national certifying body?

   a. _____ At least 30 contact hours*, as part of a master's degree program from an accredited college/university, of advanced pharmacology education, including advanced pharmacotherapeutics that is integrated into the curriculum? ..... YES NO

   OR

   b. _____ At least 30 contact hours* of advanced pharmacology, including advanced pharmacotherapeutics, from an accredited college/university? ..... YES NO

   OR

   c. _____ At least 30 contact hours* of continuing education from a Hawaii Board of Nursing approved recognized certifying body, in advanced pharmacology, including advanced pharmacotherapeutics related to your practice specialty? ..... YES NO

   Name of school/provider: _____

** Contact hours means a minimum of fifty minutes of actual organized instruction. Academic credit shall be converted to contact hours as (1) one quarter academic credit = 10 contact hours, or (2) one semester academic credit = 15 contact hours.*

(Continued on Back)

App	700	$50
RX fee	705	$20
CRF	C13	$35/$70
½ Ren	706	$20
Service Fee	BCF	$15

4. Do you have at least 1,000 hours of clinical experience in an institution as a Hawaii Nursing Board-recognized APRN practitioner in your nursing practice specialty, within a three-year period immediately preceding the date of this application AND have you completed and enclosed the Certification of Clinical Experience form? ..... YES NO

5. In the past twenty years, have you ever been convicted of a crime for which the conviction has not been annulled or expunged?..... YES NO
If "YES", arrange to have certified court documentation on the date, place, violation for each conviction and fulfillment of conditions of each sentence sent directly to DCCA.

6a. List all states in which you are currently recognized or licensed as an APRN-RX:

State _____ No. _____ Expiration Date _____

State _____ No. _____ Expiration Date _____

State _____ No. _____ Expiration Date _____

b. Has any of the above prescriptive authority, recognition, or licenses ever been revoked, suspended, or otherwise subject to disciplinary action? ..... YES NO
If "YES", arrange to have certified documents from the state in which disciplinary action was taken, sent directly to DCCA. (Include Findings of Fact, Conclusion of Law, Recommended Order, Final Order, and whether you have been reinstated. If re-instated, date and conditions of license.)

c. Are you presently being investigated or is any disciplinary action pending against any of the licenses, prescriptive authority, recognitions, certifications, or registrations you hold?..... YES NO
If "YES", arrange to have certified documents from the state in which disciplinary action or investigation is pending against you, sent directly to DCCA.

AFFIDAVIT OF APPLICANT:

I, hereby, certify that the answers and statements contained in this application and the documents are true and correct. I also certify that I have read, understand, and agree to comply with Chapter 89C, Hawaii Administrative Rules for Advanced Practice Registered Nurse Prescriptive Authority. I understand that any misrepresentation is grounds for refusal or subsequent revocation of recognition (Section 710-1017, Hawaii Revised Statutes.)

_____ _____

Date Signature of Applicant

STATE OF HAWAII
ADVANCED PRACTICE REGISTERED NURSE
PRESCRIPTIVE AUTHORITY RECOGNITION PROGRAM
Department of Commerce and Consumer Affairs
1010 Richards Street, P.O. Box 3469
Honolulu, HI 96801

CERTIFICATION OF CLINICAL EXPERIENCE

_____
(print name of applicant)

This is to certify that _____
(name of applicant)

has practiced as a Hawaii Board of Nursing-recognized Advanced Practice Registered Nurse in the area of

_____ at _____ hours per
(nursing practice specialty) (no. of hours)

week from _____ through _____ for a total of _____ hours
*(month/day/year) (month/day/year) (number)

at the institution named below.

_____
Signature (Employer) (Date)

_____
Print Name

_____
Title

_____
Name of Institution

_____
Address

_____
City State Zip Code

( ) _____
Telephone Number

* This date cannot be earlier than the date applicant received APRN Recognition from the Hawaii Board of Nursing.

THIS FORM MAY BE DUPLICATED

_____Initial

_____ Modified

STATE OFFICE USE ONLY

Recognition No. APRN-RX	Eff. Date	Exp. Date
APPROVED:	Initial/Date	

COLLEGIAL WORKING RELATIONSHIP AGREEMENT BETWEEN A RECOGNIZED ADVANCED PRACTICE REGISTERED NURSE AND A PHYSICIAN(S)

This form may be used for collegial working relationship agreements with multiple physicians provided each physician separately answers all the questions, signs and notarizes his/her portion of this document. This form can also be duplicated if there are more than 4 collegial working relationship agreements. This form must be filed for approval at least 5 weeks prior to the intended implementation of the below named collegial working relationship.
Note: Modification of the Collegial Working Relationship Agreement after approval of the initial agreement requires a fee of $50.

I. Name of APRN seeking prescriptive authority _____

Business address _____ _____ Business phone number _____ Emergency/after hours phone number

Board of Nursing approved practice specialty _____

II. Collegial Working Relationship Physician(s) (**INCLUDING INTERIM PHYSICIAN'S** which should use the code "I" in the License Name column):

Physician's License Name	Physician's Hawaii License No. and Expiration Date	Affiliated Institution of Practice w/ APRN-RX	Area of Practice	Certify to a. below (yes or no)	Certify to b. below (yes or no)	If applicable, list any limitation to the Exclusionary Formulary	Department Use only (approved/disapproved)
1.							
2.							
3.							
4.							

a. I am actively engaged in the same or related specialty practice and affiliated with the same institution in which the above-named APRN-RX is to practice.

b. In my collegial working relationship with the above-named APRN-RX, I have established methods of communication between myself and the APRN-RX.

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Modif Fee..... 707 ..... $50

_____
Name of APRN seeking prescriptive authority

III. For the APRN-RX candidate and physician(s): The notarized signature below represents our attestation of the following:

a. We certify that we jointly acknowledge and accept the responsibility that the collegial working relationship is based upon written policies for the delivery of health care services that will have the interest and welfare of the patient foremost in mind;

b. We certify that we acknowledge and accept the responsibility that the above-named APRN who is applying for prescriptive authority shall be governed by the exclusionary formulary (or any limitations named above) and that there shall be strict adherence to the exclusionary formulary (or any limitations named above);

c. We certify that the collegial working relationship shall not commence until the Department of Commerce and Consumer Affairs has granted approval;

d. We certify that we will notify the Department of Commerce and Consumer Affairs, at least 10 working days prior to any modification of any of the above stated information and attestations, and such modified collegial working relationship shall not commence until after the Department has granted approval; and

e. I agree to provide notice to the Department of Commerce and Consumer Affairs within 3 calendar days, when our collegial working relationship is terminated.

(Collegial Working Relationship Agreement 1)

Subscribed and sworn to before me
this _____ day of _____, 20____
_____
Notary Public, State of _____
My commission expires: _____

_____
APRN-RX signature

Subscribed and sworn to before me
this _____ day of _____, 20____
_____
Notary Public, State of _____
My commission expires: _____

_____
Physician signature

(Collegial Working Relationship Agreement 2)

Subscribed and sworn to before me
this _____ day of _____, 20____
_____
Notary Public, State of _____
My commission expires: _____

_____
APRN-RX signature

Subscribed and sworn to before me
this _____ day of _____, 20____
_____
Notary Public, State of _____
My commission expires: _____

_____
Physician signature

(Collegial Working Relationship Agreement 3)

Subscribed and sworn to before me
this _____ day of _____, 20____
_____
Notary Public, State of _____
My commission expires: _____

_____
APRN-RX signature

Subscribed and sworn to before me
this _____ day of _____, 20____
_____
Notary Public, State of _____
My commission expires: _____

_____
Physician signature

(Collegial Working Relationship Agreement 4)

Subscribed and sworn to before me
this _____ day of _____, 20____
_____
Notary Public, State of _____
My commission expires: _____

_____
APRN-RX signature

Subscribed and sworn to before me
this _____ day of _____, 20____
_____
Notary Public, State of _____
My commission expires: _____

_____
Physician signature